

FILED FEB 24 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

6731

State File No.

BIRTH NO. REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **1272**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Alexian Bros. Hospital		d. STREET ADDRESS (If rural, give location) 3933 S. Broadway	
3. NAME OF DECEASED (Type or Print) a. (First) MICHAEL b. (Middle) G c. (Last) Lester HENN		4. DATE OF DEATH (Month) (Day) (Year) Feb. 7 1950	
5. SEX D	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) single	8. DATE OF BIRTH Nov. 28, 1894
9. AGE (In years last birthday) 55		10. CITIZEN OF WHAT COUNTRY? Illinois	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clergy		10b. KIND OF BUSINESS OR INDUSTRY	
13a. FATHER'S NAME Unknown		13b. MOTHER'S MAIDEN NAME Unknown	
14. NAME OF HUSBAND OR WIFE		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	
16. SOCIAL SECURITY NO. no		17. INFORMANT'S SIGNATURE OR NAME Hospital Records ADDRESS 3933 S. Broadway	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Melanotic Melanoma ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT SUICIDE HOMICIDE (Specify)	
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) 1901	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?		22. I hereby certify that I attended the deceased from Sept. 1949 , to Feb. 7, 1950 , that I last saw the deceased alive on Feb 7 , 1950, and that death occurred at 4:40 P. M. , from the causes and on the date stated above.	
23a. SIGNATURE R. A. Magee M.D. (Degree or title)		23b. ADDRESS 539 N. Grand, St. Louis	
23c. DATE SIGNED 2/8/50		24. NAME OF CEMETERY OR CREMATORY Wilmette, Illinois	
24a. DATE REC'D BY LOCAL REG. FEB 8 1950		24b. DATE 2-8-50	
24c. NAME OF CEMETERY OR CREMATORY		24d. LOCATION (City, town, or county) (State)	
25. FUNERAL DIRECTOR'S SIGNATURE Weick Bros. Und. Co. ADDRESS 2201 S. Grand Blvd.			

(Licensed Embellisher's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

_____ Student Embalmer No. _____
working under my personal supervision.

Student
Student Embalmer

Signed James R. Dunn
Licensed Embalmer No. 4527
P. O. Address 2201 S. Grand

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.